

**ICD-9-CM/ICD-10-CM/PCS Coordination and Maintenance Committee Meeting
Summary of Diagnosis Presentations
September 18-19, 2013**

Donna Pickett, co-chair of the committee, welcomed the members of the audience to the diagnosis portion of the meeting. Ms. Pickett reviewed the timeline included at the beginning of the topic packet informing the attendees of the deadline for written comments on topics presented at this meeting. Except where noted, all topics are being considered for implementation on October 1, 2015. The addenda items are being considered for implementation prior to October 1, 2014.

Written comments must be received by NCHS by November 15, 2013. Ms. Pickett requested that comments be sent via electronic mail to the following email address nchsid9CM@cdc.gov since regular mail is often delayed. Telephone contact information for all NCHS staff and the NCHS website are included in the topic packet. Attendees were also reminded that the full topic packet is currently posted on the NCHS website. New proposals for the March 19-20, 2014 meeting must be received by January 17, 2014.

NCHS will no longer provide a hard copy continuing education (CE) certificate for this meeting. Attendees were instructed to contact the respective professional association for further information on CE reporting details. NCHS will continue to report, in this summary, the number of hours for each day of the meeting. The September 18, 2103 meeting was adjourned at 3:00 pm; attendees may be eligible for 3 CE hours. The September 19, 2013 meeting adjourned at 10:47 am; attendees may be eligible for 2 CE hours.

Comments and discussion on the topics presented on September 18, 2013 were as follows:

Periprosthetic Fractures

Nelly Leon-Chisen, representing the American Hospital Association (AHA), expressed concern on how one would know the difference if it was a traumatic or pathological fracture, since use of the external cause codes is discretionary and not mandated in all states. There may be a need to use another code to indicate that.

Dr. Berglund, NCHS, commented that it would be possible to add either an Excludes 1 note so that they can't be used together or Use additional code note, if these should be used together. Ms. Leon-Chisen also stated that AHA submitted a comment to the FY14 IPPS proposed rule that they oppose implementation of any new codes on October 1, 2014. AHA believes that it would be too confusing to introduce new codes at the same time ICD-10-CM and ICD-10-PCS go live. AHA stated that this is going to be a year of intense testing and introducing changes may cause misinterpretation of test results.

Dr. James Nagel, Upper Chesapeake Medical Center, asked how intraoperative fractures will be handled given that these fractures can happen during preparation of the femoral component of

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surgery. Dr. Berglund stated that would be coded at M96.6 and that is why an Excludes 2 note will be at the proposed new category M97.

Dr. Nagel also expressed concern about the proposed M97 codes stating his preference of knowing what bone is fractured. He indicated that the term “joint” is not specific enough, since there is a bone on each side of the joint, with an example of a hip joint potentially involving wither the femur or the pelvis.

Sue Bowman, representing the American Health Information Management Association (AHIMA), supported the comments made by AHA. AHIMA has heard from members, vendors and payers that it would be very difficult if codes were added during implementation.

Periorbital (Preseptal) Cellulitis

A commenter stated that currently in the index there is no guidance for coders on this, and in the absence of a new code for 10/1/2014 there needs to be an index entry to direct the coder either to the face or the orbit as new code is introduced on October 1, 2015. Another interim solution suggested was an article in AHA’s Coding Clinic for ICD-9-CM. Nelly Leon-Chisen, AHA, commented that they had received a similar question and that an interim response is expected to be published in an upcoming issue.

Observation and evaluation of newborns for suspected condition not found

Ms. Bullock noted that there is an error in the topic packet and that the code Z05.1 was inadvertently deleted, but will be added in the topic packet and reposted.

Sue Bowman, AHIMA, stated that she does not like category P00. Ms. Bowman also suggested an Excludes 2 note under the Z05 category instead of an Excludes 2 so they don’t prohibit the use of these codes together on the same chart, if the patient has two different conditions (one not yet ruled out and one that is ruled out).

Linda Holtzman, of Clarity Coding, asked how the P00 fits in with the coding guidelines for coding an uncertain diagnosis. It could be confusing for the scenario when an infant is observed for a specific condition and treatment is started whether or not the condition is confirmed or ruled out. If it is not ruled out, it is not clear if one should code the specific condition or a P00 code. There is too much overlap or there is a need for clearer guidelines on use of the codes in the category P00 codes and the specific diagnosis code for the condition that is not ruled out.

Becky Dolan, American Academy of Pediatrics (AAP), commented that their intent of the proposal was to retain the P00 codes to be used for conditions that have not been ruled out by the time of discharge, that are related to maternal issues or the birth process. The proposed Z05 codes were intended to be used for conditions unrelated to the birth process. Sometimes these could be environmental factors within the first 28 days of life or for cases where the child is brought into the ER or the provider’s office and the suspected condition is ruled out.

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Dr. James Nagel, from Upper Chesapeake Medical Center, commented that as a former pediatrician he agrees with the AAP proposal. Also, he suggested adding either “found not to exist” or “ruled out” to the end of each of the proposed Z05 codes; this suggestion was supported by another commenter. For example:

Z05.1 Encounter for observation of newborn for suspected infectious condition, ruled out

Vaccine and prophylactic immunotherapy administration

Dr. James Nagel, Upper Chesapeake Medical Center, commented that he supports adding in more specificity for these vaccinations. He also suggested seeking input from the Advisory Committee on Immunization Practices (ACIP) regarding recommendations on certain vaccines and if others should be added. Specifically he recommended considering codes for vaccines for rotavirus, and meningococcal disease.

Darlene Hyman, of Upper Chesapeake Medical Center, indicated that she prefers to just have one code for the vaccine, and then code the specific type of vaccine using a procedure code. She does agree with a code for encounter for RhoGam injection.

Donna Picket indicated that there are philosophical issues here regarding how much detail a disease classification should have about what appears to be procedures. She invited participants to submit comments on these issues.

Sue Bowman, AHIMA, recommended changing the Excludes1 notes at these codes so that one could code multiple encounters for vaccination codes together when needed (example an MMR vaccine given at the same time as a separate tetanus vaccine).

Nelly Leon-Chisen, AHA, recommended further review of the Hemophilus influenzae type B and whether that is too specific.

Becky Dolan, AAP, commented that their intent with this proposal was to retain one code for encounter for routine vaccines but to have separate codes for vaccines that are given in other types of settings or for non-routine reasons. Examples of these included giving a tetanus vaccine in an inpatient setting or a rabies vaccine (which is not routinely given to everyone). They did not intend to have all of the ICD-9-CM prophylactic vaccine codes carried over to ICD-10-CM and indicated that their members actually do prefer having one code for routine vaccines.

Encounter for prophylactic or treatment measures

It was noted that the proposed new code, Z51.6 Encounter for desensitization to allergens, is being proposed in category Z51 to match where it already exists in ICD-10.

There were no comments on this proposal.

Conductive and Sensorineural Hearing Loss

There were no comments on this proposal.

Somnolence, stupor and coma

Linda Holtzman, Clarity Coding, asked for confirmation that if you have a full coma scale documented then one should use one code from each the three R40.21-R40.23 subcategories and if only a total score is documented then one should use a code under R20.24. NCHS confirmed this as correct.

Dr. James Nagel, Upper Chesapeake Medical Center, asked who typically documents the GCS score as well as what documentation will be accepted for this score. He also asked whether the guidelines are clear on acceptance of non-physician documentation of this score to be used for coding. Ms. Pickett, NCHS, indicated that there are notes in the tabular that specify when the score is taken and in what environment and setting it was taken.

Sue Bowman, AHIMA, commented that they recently received comments asking that this same issue be addressed in the next guidelines update.

Ms. Pickett indicated that the guidelines will be reviewed and revised, if necessary.

Periodontology related terms

There were no comments on this proposal.

Endodontology-related terms

Endodontology classification is done on two dimensions – symptomaticity and reversibility – both of which have implications for the clinical management of patient presentation. Currently in ICD-10-CM, the same code (K04.0) is used for both reversible and irreversible pulpitis. It is proposed to differentiate these two concepts, creating separate codes for them, since these diagnoses have significantly different treatment implications.

There were no comments on this proposal.

Caries terms

Sue Bowman, AHIMA, suggested spelling out the acronym DEJ when it is used in the inclusion term for recurrent caries.

Other Dental Terms

There were no comments on this proposal.

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA

All addenda items are proposed to be effective October 1, 2014. NCHS encourages comments on the proposed changes as well as whether they should be implemented during the partial freeze and at the same time as ICD-10-CM goes live. Some of these changes were suggested by users,

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some are considered typographical errors and others are ICD-10 updates approved for January 2014 implementation by WHO and therefore need to be added as soon as possible.

Pat Brooks, from the Centers for Medicare and Medicaid Services (CMS), indicated that they strongly recommend that no code title changes be made for October 1, 2014. She said that for payors and providers these types of changes can require extensive system changes and they should be deferred to October 1, 2015.

Nelly Leon-Chisen, AHA, concurred with the comments made by CMS, although they realize that there are problems that should be addressed for 10/1/2014, especially where edits might preclude coders from using codes properly. However, it would be especially helpful if the addenda could be released early in 2014, rather than in spring/summer, to allow system changes to take place early enough to test them before ICD-10-CM implementation.

Sue Bowman, AHIMA, agreed with the earlier comments made. She indicates that this differs from AHIMA's position early on where they recommended that any "errors" be fixed prior to October 1, 2014. She indicated that having to make changes be effective the same day as ICD-10-CM was implemented could be asking too much on end users. There is too much possibility that something will be missed or misinterpreted.

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA

There were no comments to the proposed index addenda.

Gastrointestinal Stromal Tumor (GIST)

Brian Rubin MD, PhD, Director of Soft Tissue Pathology at The Cleveland Clinic Lerner Research Institute and Taussig Cancer Center was available for clinical questions via teleconference. Dr. Rubin provided some clinical information about how GIST can be treated with a class of drugs called tyrosine kinase inhibitors.

Linda Holtzman, Clarity Coding, asked Dr. Rubin if GIST will always be malignant and stated if so then there is a need to update the index to show this. Ms. Holtzman also suggested adding the acronym GIST to the index. She also suggested adding an Excludes note at C49.4 to direct the coder to C49.A if they are coding GIST.

Nelly Leon-Chisen, AHA, added that in addition to the index, that a revision to the table of neoplasms is needed.

Oral and maxillofacial fractures

James E. Mercer, DDS, Oral and Maxillofacial Surgeon, AAOMS Committee on Healthcare & Advocacy was available for clinical questions via teleconference.

There were no comments on this proposal.

Oral and maxillofacial fractures

There were no comments on this proposal.

Temporomandibular joint disorders

There were no comments on this proposal.

Dislocation and sprain of joints and ligaments – Jaw

There were no comments on this proposal.

Comments and discussion on the topics presented on September 18, 2013 were as follows:

Unintended awareness under general anesthesia

One commenter offered his testimony of personal experience of unintended awareness under general anesthesia. He indicated that he has suffered long term post-traumatic stress disorder (PTSD) as a result. He expressed hope for approval of the proposed codes indicating that he thinks the codes will help validate the condition and provide more treatment opportunities to the patients who suffer from the complication.

Binge Eating Disorder

Darrel A. Regier, M.D., M.P.H. representing the American Psychiatric Association, provided a summary of the DSM-5, released in May 2013, and then provided clinical background on this topic.

There were no comments on this proposal.

Gender Identity Disorder in Adolescence and Adulthood

Changes are being recommended by APA for October 1, 2014.

There were no comments on this proposal.

Disruptive Mood Dysregulation Disorder

Darrel A. Regier, M.D., M.P.H. representing the American Psychiatric Association, provided clinical background on this topic.

Changes are being recommended by APA for October 1, 2014 and October 1, 2015.

There were no comments on this proposal.

Social (Pragmatic) Communication Disorder

Darrel A. Regier, M.D., M.P.H. representing the American Psychiatric Association, provided clinical background on this topic.

There were no comments on this proposal.

Hoarding Disorder

Darrel A. Regier, M.D., M.P.H. representing the American Psychiatric Association, provided clinical background on this topic.

Changes are being recommended by APA for October 1, 2014 and October 1, 2015.

Ms. Pickett stated that new code proposal starting at F42.2 is due to F42.0 and F42.1 deactivation by WHO.

There were no comments on this proposal.

Excoriation (Skin-Picking) Disorder

Darrel A. Regier, M.D., M.P.H. representing the American Psychiatric Association, provided clinical background on this topic.

Changes are being recommended by APA for October 1, 2014 and October 1, 2015.

Ms. Pickett commented that placement should focus on correct placement in the classification and not on reimbursement insurance company issues. Ms. Fisher stated that it might be a better placement at F42 for trend data, further review may be needed.

A question was raised that if excoriation (skin-picking) disorder is really a mental health disorder, would a better alternative be to classify this under F42, even though F42 does not have a breakout at this point?

To classify this under L98.1 and not F42 would interrupt trend data. For example for one year you would code Excoriation (skin-picking) disorder at the L98.1 and the following year at the F42 category.

Ms. Pickett asked about the possibility that a patient could have both excoriation (skin-picking) disorder and factitial dermatitis, since in the proposal for F42.4, there is an Excludes 1 note meaning they are exclusive of each other and the codes can't be used together. If this were the case, then would it be better to have an Excludes 2 and therefore be able to use the codes together. Dr. Regier responded that their expectation is that they should be used separately.

Premenstrual Dysphoric Disorder

Darrel A. Regier, M.D., M.P.H. representing the American Psychiatric Association, provided clinical background on this topic.

Additional Tabular List Inclusion Terms for ICD-10-CM

Ms. Pickett reviewed an additional list of inclusion terms being requested and indicated that corresponding index changes would be done.

There were no comments on this proposal.

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Intracranial injury (TBI)

Luanna Ciccarelli, representing the American Academy of Neurology, (AAN) stated that they agree with the proposed deletions however they are opposed to adding the inclusion term mild traumatic brain injury (TBI) to Concussion. The AAN feels that mild TBI is a severity measure and concussion is a neurophysiological process and they are not synonymous terms. She further stated that while concussion with a loss of consciousness of less than 30 minutes may result in TBI not all TBI is a concussion.

There was a comment from AHIMA opposing the implementation of these proposed changes in 2014 as they do not meet the criteria for implementation during the code freeze. They are too major to implement on the ICD-10 “go live” date.

Also, how would a diagnosis of concussion with LOC greater than 30 minutes be coded? Is the coder supposed to tell the physician his diagnosis of concussion is incorrect?

Placenta Previa vs Low Lying Placenta

There were no comments on this proposal.